



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Medme Services Corporation

Respondent Name

El Paso County

MFDR Tracking Number

M4-15-1473-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

January 20, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Payment for date of service 04-03-14 has been made. However, the payment was well under the allowable amount according the Medicare and TWCC Fee Guidelines."

Amount in Dispute: \$95.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgment of medical fee dispute received however, no position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 3, 2014	E0730, RR	\$95.89	\$20.59

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 217 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement

Issues

1. Did the requestor support that additional payment is due?
2. Is the requestor entitled to reimbursement?

Findings

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on January 28, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.
2. The Carrier reduced the billed amount on the medical claim as 217 – "Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement." 28 Texas Labor Code §134.203 (d) states in pertinent part, "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;" Review of the DMEPOS fee schedule finds the following;
 - a. The Medicare, 2014, Texas Fee Schedule amount found at www.dmeptac.com/dmecsapp/do/feesearch, for submitted code (E0730) is \$391.22
 - b. Per Medicare Claims Processing Manual, Chapter 20, 30.1.2, "In order to permit an attending physician time to determine whether the purchase of a TENS is medically appropriate for a particular patient, contractors pay 10 percent of the purchase price of the item for each of 2 months"Therefore, per the CMS instructions and Division fee guidelines, $\$391.22 \div 10 = \$39.12 \times 125\% = \$48.90$.
3. The total allowable for the services in dispute is \$48.90. The Carrier previously paid \$28.31. The remaining balance of \$20.59 is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$20.59.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$20.59 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

April , 2015
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.